Hospital Sisters
HEALTH SYSTEM

January 22, 2014

TO: **Health and Medicine Policy Research Group**

FROM: **Tim Eckels, Vice President, Public Policy and Advocacy, HSHS**

RE: **Input on Draft 1115 Waiver Application**

Hospital Sisters Health System (HSHS) appreciates the opportunity to submit comments on the draft 1115 Waiver Application for Illinois Medicaid (the "Application").

HSHS is the one of the largest downstate systems in Illinois, including eight hospitals, a multispecialty physician group (HSHS Medical Group), and Prairie Cardiovascular Consultants – all of which serve broad sections of Central and Southern Illinois. We are a healing ministry, guided by the historic mission of the Hospital Sisters of St. Francis – with a special emphasis on the poor and underserved.

As described in our previous comments, HSHS has been pursuing a Care Integration strategy since 2008 with the same goals for patient-centered, coordinated, and efficient care envisioned by Pathway #1 in the Application. This includes a Physician Clinical Integration Network comprised of nearly 800 independent physicians that are collaborating with HSHS in pursuing value-based payment systems. We sponsor 15 Patient-Centered Medical Home pilot sites that use on-site "nurse navigators" to improve care for patients with chronic conditions. HSHS also actively participates in a "Medicaid Collaborative" that is committed to value-based solutions for care to Medicaid patients and rural and downstate geographies. The Collaborative includes HSHS, Central Counties Health Centers, the Southern Illinois University (SIU) School of Medicine, and Southern Illinois Healthcare Foundation.

HSHS again commends the State for the Application's commitment to accelerating the development of a better and more efficient delivery system to meet the needs of our most vulnerable residents. We remain concerned, however, that the complex and multifaceted nature of the Application could result in a diffusion of funds that could hurt the overall effort to

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transform the delivery system. We encourage the State to ensure that the overall approach is focused and integrated, and that it not be driven by the desire to address too many discrete issues and redeploy resources to too many organizations and interests. The result could be a reallocation of scarce resources away from the organizations that are most needed in order to create the "integrated, rational and efficient healthcare delivery system" envisioned by the document.

This focus could be achieved by unifying and integrating the application around the development of the Integrated Delivery Systems (IDSs) envisioned in the document. These IDSs – especially as developed by the physicians, hospitals, and other entities that are actually providing care to patients – hold the most promise for a sustainable Medicaid program. We urge the State to use this concept as a filter. If any initiative in the Application is not clearly linked to the successful development of IDSs, it should either be integrated with this primary goal or removed from the approach. Otherwise, the State risks a diffusion of scarce resources and an underinvestment in care transformation.

Pathway 1: Transform the Health Care Delivery System

We support the State's overall approach to the use of incentive payments designed to stimulate the development of IDSs. We are especially encouraged by the range of supports and the ITRC concept outlined in this section. We want to ensure, however, that this funding and the supports will be available to organizations that are clearly on the path to IDS development even though they may not yet have the capabilities to be an ACE or CCE. Otherwise, the State will have bypassed organizations like HSHS that are already making significant investments in care coordination and that are committed to more efficient systems of care for broad swaths of downstate Illinois.

To this end, we recommend that the performance metrics used to qualify for incentive payments include indicators of an organization's commitment to and demonstrated progress toward IDS capability, such as (1) the existence of Medical Homes that are certified by NCQA; (2) investment in a population health management data system; (3) existence of a formal Clinical

Integration Network that is testing value-based payment models; (4) a threshold number of value-based payment provisions secured with Medicaid MCOs, Medicare Advantage, and/or commercial payers; and (5) EHR adoption (as already listed on page 18).. These kinds of metrics will allow the State to harness the energy, commitment, and geography of health systems that are still developing the care coordination mechanisms that are needed to achieve outcome metrics.

While the State proposes a separate IDS incentive pool for "distressed hospitals," this term is not defined. We urge the State to avoid using the types of Medicaid caseload thresholds often associated with "safety net" hospitals. Many downstate hospitals may not meet these thresholds, and yet they are vital to Medicaid access in rural Illinois while facing significant financial and logistical challenges associated with rural healthcare.

We also urge the State to include a Rural Health Innovations Program (RHIP) in the Application. The State's original "concept paper" included this provision, but it does not appear in the Draft Application. The organizations serving rural Illinois face a special set of challenges in the development of IDSs, such as transportation, workforce shortages, limited post-acute choices, and the need for remote treatment options. We support the RHIP concept as outlined by the IHA in their comment letter, especially the emphasis on telemedicine technologies as a critical tool for coordinating care across settings and ensuring real-time access to specialty care. Support for Patient-Centered Medical Homes (PCMHs) is also critical. Without this RHIP concept or something like it, we are concerned that the Waiver will result in an imbalance of overall innovation funding to large urban areas due to the number and size of organizations in those areas.

As described in our previous comments, the Application also needs to incentivize MCOs to partner with providers on care management and delivery system reform. We recognize that physicians, hospitals, and other providers will often need to partner with MCOs to develop sustainable IDS capabilities as described above. We are very concerned that this will not happen if MCOs rely on simple fee-for-service rate reductions, payment delays, and utilization reviews. These incentives (which would apply to all organizations working toward financial risk

– not just MCOs) could include requirements for shared savings models, quality targets, performance bonds, medical loss ratios, and rate floors. A rate floor, for example, would ensure minimal funding for enrollees who really need hospital care while encouraging MCO/provider partnerships that can achieve savings through better coordinated care, improved enrollee health, and reduced hospitalizations.

We also want to reiterate our recommendation that the State consider alternatives to the uncompensated care pool or "access assurance pool." This concept is not clearly defined in the Application, and we remain very concerned that it could result only in a shifting of dollars without contributing to IDS development and more efficient care. We cannot support another program that simply replaces one complex hospital payment system in which dollars do not follow the patient (e.g. "current fixed supplemental payment programs") with another such system that still fails to direct payments based on the volume and acuity of patients served. We understand that one purpose of the pool is to protect payments from the Upper Payment Limit that could result from shifting of Medicaid enrollees into managed care. Before moving to an uncertain solution, we urge the State to debate and consider all solutions that reduce the risk to the UPL. These include: (1) moving all supplemental payments into fee-for-service rates (as in most other states), (2) revising State law to extend the current provider tax without modification, or (3) requesting a waiver to apply all current Medicaid payments to the fee for service and managed care populations.

Pathway 3: 21st Century Health Care Workforce

HSHS appreciates provisions in the Application that are designed to support training for primary care and access in rural areas, including support for GME. In partnership with Southern Illinois University (SIU) School of Medicine, St. John's Hospital in Springfield provides training in programs that emphasize primary care and serve as vital sources for health professionals that practice in rural areas – including several Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas (MUAs). Our St. John's College of Nursing in Springfield trains other health professionals that stay predominantly in Illinois, often in underserved areas. St.

Elizabeth's Hospital in Belleville also supports a teaching program. To ensure support for downstate programs such as these, we urge you to:

- Keep the Application language focused on programs that support primary care and access in underserved and/or under-resourced areas;
- Support efforts to allow clinical staff to practice to the full extent of their training as described in the comment letter submitted by the Illinois Hospital Association, thereby enhancing access in rural areas through the use of midlevel practitioners;
- Ensure that the "distressed hospital" definition for the loan repayment program includes facilities that serve rural areas even though their Medicaid caseloads may not reach the thresholds typically used when referring to "safety net hospitals;"
- Open the "Teaching Health Center" program to facilities not currently funded;
- Retain the part of the GME incentive funding formula that distributes the designated funds equally among all qualifying programs, a factor that will encourage participation by downstate programs that may be smaller than their urban counterparts, but that play a key role in rural access for underserved populations; and
- Omit the reference to "other health professions shortage areas defined by the state" under the "year three "section on page 28. We believe that the HPSA and MUA designations are adequate and we are concerned that an "other "category will allow for an unnecessary diffusion of scarce funds.

We also recommend that the series of annual formulas for GME incentive funding be prefaced with an explanation of what the State is trying to achieve regarding the locus and distribution of supported programs. The current draft is unclear on this point, leaving considerable ambiguity about why the State is using such particular calculations and sequencing of formulas.

HSHS appreciates this opportunity to comment and looks forward to working closely with the State as this process continues. Questions about these comments can be directed to Tim Eckels at Tim.Eckels@HSHS.org, 217-492-9158.